Phone: 616-954-0600 Fax: 616-954-1675

Aralast NP IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: ______________________________ **Patient Weight:** _________lbs / kg **Height:**_____________

ICD-10 : ________________________, ___________________________, ___________________________

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Does the patient have emphysema? ☐ No ☐ Yes
What is the patient's baseline percent predicted FEV_1 _________________
What is the patient's baseline serum AAT level? _____________________

Labs to be collected: ☐ BMP ☐ CMP ☐ CBC w/o diff ☐ CBC w/diff ☐ CBC w/man diff ☐ Other: __________

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:________________

Aralast NP (alpha$_1$-proteinase inhibitor) IV

Dosage: 60 mg/kg Other:________________

Frequency: Every Week

Printed Provider Name: ____

Provider Signature: ____

Office Phone Number: _____________________**Office Fax Number:** _______________________________